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Canada

Geriatric Services in Acute-Care Hospitals:
A: Geriatric Assessment and Treatment Units
B: Geriatric Day Hospitals

Guidelines

REPORT OF THE SUBCOMMITTEE ON INSTITUTIONAL PROGRAM GUIDELINES

Guidelines for Establishing Standards for:

GERIATRIC SERVICES IN ACUTE-CARE HOSPITALS

A: GERIATRIC ASSESSMENT AND TREATMENT UNITS
B: GERIATRIC DAY HOSPITALS

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NOTE

The information contained in these guidelines is considered current as of the date of approval; however, since health care and health technology are constantly changing fields, any suggested amendments would be welcomed. Information on new developments or related issues should be directed to:

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■ PREFACE

Technological advancements and changes in the delivery of health care services have led to the need for guidelines to assist in planning and implementing health programs and services in institutions and the community. The guidelines[1] that follow represent one of a series of publications produced under the direction of the Subcommittee on Institutional Program Guidelines. They provide a consistent definition of requirements for a number of special-care units, services and programs in health institutions and the community.

In general, guidelines are based on information, knowledge, experience, research and expert opinion from health professionals and organizations throughout Canada. Additional material is often obtained from national and international health organizations and from other experts knowledgeable in the subject. In this way, many Canadians from across the country can contribute to the guidelines, and a consensus on the suggested approach can be achieved.

Background

Under the direction of the Federal/Provincial/Territorial Advisory Committee on Institutional and Medical Services, the guidelines program has been in operation since 1972. A standing subcommittee of the Advisory Committee, the Subcommittee on Institutional Program Guidelines, composed of federal and provincial government and professional representatives, coordinates the development of the guidelines commissioned by the Advisory Committee.

The guidelines are produced by expert working groups of health professionals, some of whom are government representatives. The final draft is reviewed and recommended by the Subcommittee, for approval by the Advisory Committee.

1 A complete list of Institutional Program Guidelines appears in Appendix IV.

Purpose

The purpose of the guidelines is to provide a comprehensive definition of requirements for health services. While a consensus of expert knowledge and experience is reflected in the guidelines, such guidelines should not be regarded as rigid standards. Provincial health authorities may modify the application of guidelines to meet their needs.

Where development of a service is being contemplated, the guidelines may help in determining the need for such a service either locally or regionally, or in some cases provincially or interprovincially.

Established services may take advantage of the guidelines to screen deficiencies and solve problems without having to develop new services. Where a service already exists, the guidelines will help to:

- identify problems related to administration, personnel, equipment and facilities,
- determine necessary remedial action, and
- set priorities for corrective measures on the basis of clinical need, funding and the degree to which the service is deficient.

Future

The dramatic increase in the number of intensive and special care services in health institutions has given rise to the need for additional facilities, specialized equipment and highly trained personnel. At the same time, new approaches to patient care have evolved in a manner that emphasizes the need for a continuum of care in which admission to an institution is only one aspect of total care. Therefore, linkages along the health care continuum, ranging from illness prevention to chronic care, must be identified. As new treatments and procedures are put into practice, there will be a continuing need for guidelines to assist those involved in the planning and operation of services.

Revisions

Due to the rapidly changing nature of health care delivery, guidelines will need updating and revision. The Subcommittee on Institutional Program Guidelines plans and oversees these revisions.

Acknowledgements

The Subcommittee acknowledges, with sincere appreciation, the immense amount of work undertaken and time given by practising Canadian health professionals in providing detailed written information and guidance throughout the preparation of these guidelines. In addition, acknowledgements are due to the many others who in any way contributed advice and information to this endeavour.

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The following guidelines result from a need to update the original guidelines, *"Geriatric Units in Hospitals, Geriatric Day Hospitals", first published in 1979. In September 1988, a Geriatric Assessment Workshop was organized by the National Advisory Council on Aging with the support of the Institutional and Professional Services Division, Health Services and Promotion Branch, Health and Welfare Canada. At that workshop, the contents of the original guidelines were discussed, together with new initiatives and approaches in the field. The proceedings of this workshop provided valuable material that was used in the guideline revision process.*

The Subcommittee is indebted to the Workshop's participants (see Appendix I), particularly to Dr. Michel Baron, who chaired the session, and to the following persons who provided topical texts on geriatric assessment in Canada: Dr. David Gayton, Dr. James Kirkland, Dr. Christopher Patterson, Dr. John Puxty and Dr. Duncan Robertson. These texts have been used extensively in revising the guidelines.

■ INTRODUCTION

Today's elderly Canadians are very independent and most live in the community without any special assistance. In planning for the care of elderly who need help, it is more relevant to consider the individual's biological, psychological and social needs than his/her chronological age. However, the older elderly, people 75 years and older, tend to require more help because of their increasing vulnerability.

Demographic projections have been discussed in many recent national reports (see Bibiliography, page 40) and there is general agreement that there will be a rapid increase in the elderly population in the coming years, the most dramatic rise being in the number of elderly aged 75 years or over.

The aim of all services for the elderly is to maintain their independence and to allow them to retain maximum control over their lifestyles. Geriatric services in acute-care hospitals are part of a spectrum of services needed to support the elderly living in a community. When hospital care is required, as in the need for inpatient care for an acute illness, the primary objective is to enable patients to return to their customary lifestyles as soon as possible.

Services in the community should be in place to give many elderly persons the appropriate support to allow them to live outside of the institutional setting. These services must be coordinated and resources are needed to do this. The following list gives examples of the wide range of health, educational and support services that are required to meet the physical, psychological and social needs of the elderly in a community.

1. Health Promotion and Illness Prevention

Primary – Activities promoting changes in lifestyle that reduce the risks associated with health conditions such as high blood pressure, e.g. smoking cessation, controlled diet.

Secondary – Case finding directed at high-risk populations can detect decline in an old person at an early stage, when intervention is most likely to slow, halt or reverse the decline.

2. **Education**

   Family and Public Education – On the aging process and the needs of the elderly.

   Education Programs for the Elderly – Retirement, Nutrition, Lifestyle, Exercise, Information Services.

   Health Professionals – Specific programs addressed to Physicians, Nurses, Rehabilitation Personnel.

3. **Primary Medical Care**

4. **Hospital Services** – Acute Care (Physical and Psychiatric Care).

5. **Housing** – Various types of housing, from fully independent living to independent living with some services.

6. **Transportation** – Public transportation adapted to elderly needs, special transportation for the disabled.

7. **Social and Recreational Services**

8. **Home Care** – Meals, Nursing, Homemaking, Supplies and Equipment, Physiotherapy, Occupational Therapy, Respiratory Therapy.

9. **Social Services** – Financial Assistance, Housing, Home Modification.

10. **Distress Response** – Information Centre, Emergency Services.

11. **Volunteer Services** – Visiting, Driving, Reading, Meal Delivery, Foster Care.

12. **Assessment, Placement, Treatment and Long-Term Follow-up** – Geriatric Inpatient Unit, Geriatric Day Hospital, Visiting Interdisciplinary Team.

13. **Day Care**

14. **Support to Families and Respite Care**

15. **Institutional Long-Term Care** – (Required for a more extended period or for respite care) – Homes for the Aged, Nursing Homes, Long-Term Care Facility.

16. **Evaluation and Research** – Individual and Program.

■ GERIATRIC SERVICES IN ACUTE-CARE HOSPITALS

1. GENERAL OVERVIEW

A variety of specialized geriatric services have been developed in Canadian acute-care hospitals in recent years. These services were established in response to local or regional planning. They are based on the recognition that the health care needs of elderly persons often differ from those of younger persons and that the elderly account for an increasing percentage of patient days in hospitals. The following facts illustrate these differences and special needs:

- After middle age, one effect of the normal aging process is progressive reduction in the individual's ability to combat ill health (failing homeostatic and immune systems).

- The presentation of illness in old age is often misleadingly different from that in younger ages and multiple medical problems are usually present in the same person.

- The elderly take more medication than younger persons (both drugs prescribed by physicians and over-the-counter drugs), thereby increasing the risk of iatrogenic illness which precipitates admission to hospital. (10-20 per cent of all elderly admissions are due to drug interactions and side effects.)

- In the older elderly, i.e. persons over 75 years, physical and psychiatric problems are more prevalent.

- The nature of acute care in a general hospital tends to encourage the older person to become dependent on others instead of retaining or regaining as much independent functioning as possible. This can lead to dependency in a few days.

- The institutional "high tech" atmosphere of the modern acute-care hospital can be confusing and alienating for the older patient.

When services for the elderly in an acute-care facility are provided in relation to the above factors, the following benefits may be realized for service providers and patients:

- Employing specialists in the field leads to more informed diagnosis and treatment.

- Appropriately trained personnel can be attracted to the service, which leads to better diagnosis and treatment.

- Services can be rationalized in a community or region, and duplication of services can be avoided.

- The environment can be adapted to elderly needs, i.e. physical, psychological, and social.

- A longer-term approach to care can be taken to allow for flexibility in areas such as meals, clothing, family involvement, etc.

- The use of resources for a strong rehabilitation component can be rationalized.

- There can be a central focus for in-service and continuing education.

- Education and training experience for students of different disciplines can be undertaken.

- Research and development in the care of the elderly can be encouraged and facilitated.

- Patients with mental health problems will not automatically be referred to a psychiatric hospital but will often be first assessed in the acute-care setting.

- Inappropriate institutionalization in a long-term care facility can often be avoided.

An organized approach to the delivery of services for the elderly in an acute-care setting may be structured in one or more of the following ways[2]:

1. A geriatric assessment and treatment unit to serve a community or region, usually located in an acute-care hospital or centre.

2 In these guidelines, only items 1 and 2 are addressed. Companion guidelines are planned for item 3, "Geriatric Treatment and Rehabilitation Units." Guidelines for items 4 and 5 may be developed in the future.

2. Day hospital services which may consist of assessment and therapeutic services delivered on an ambulatory basis where health professionals are significantly involved.

3. A geriatric treatment and rehabilitation unit should be organized to supply the programs required to meet the needs of the elderly patient in hospital.

4. Multidisciplinary outpatient services that are structured to meet the needs of the elderly where the local population is aging and where a high percentage of the patient population receiving services is elderly, and/or where the presenting problem is more prevalent in the elderly, such as Alzheimer's disease and related disorders, diabetes and osteoporosis clinics, continence clinics, etc. These clinics can be more effective than other kinds of outpatient follow-up for the elderly with multiple problems.

5. Visiting interdisciplinary teams from the facility or the community also serve the elderly. Their objective may be to assess/treat the patient in his/her home; to assess the person; to provide consultation to community workers/family.

■ GERIATRIC ASSESSMENT

1. PREAMBLE

Geriatric assessment units and services in Canada have developed over the past twenty years. Early initiatives in the field came from the Department of Veterans Affairs, which set up assessment, re-establishment/rehabilitation units across Canada. These units initially served returning World War II veterans, but later the services were extended to veterans of previous wars who were in need of this type of help. Today, in every province, a number of hospitals and care centres have indicated that they have an assessment/evaluation component in their geriatric services.

2. DEFINITION[3]

The aim of geriatric assessment, treatment and rehabilitation[4] is to help elderly people to regain or maintain optimum health, fitness and independence and to ensure that they retain maximum control over their lifestyles.

Geriatric assessment is a set of procedures for assessing the person's total needs, i.e. physical, psychological, functional, environmental and social characteristics. Assessment determines the services needed to improve one's ability to carry out the normal activities of daily living. It is used as a basis for a plan of care and for monitoring the effects of prescribed services and activities in achieving treatment goals.

3 Definitions are derived from: The National Advisory Council on Aging, *Geriatric Assessment: The Canadian Experience* and Selby, P. and Schechter, M. in consultation with the United Nations Centre for Social Development, *Aging 2000 – a Challenge for Society*.

4 As previously stated, the important component of rehabilitation will be addressed in companion guidelines.

3. POPULATION TO BE SERVED

Most elderly persons who require medical treatment for a single-system disease do not need comprehensive geriatric assessment and rehabilitation services. Experts in the field have identified the following individuals/conditions that would benefit from this sophisticated level of care:

- Elderly persons with a decline in functional abilities – especially in activities of daily living; a new onset of falls, incontinence and confusion.

- When deterioration in health or functional status leads to contemplating a higher level of care – especially a move to a chronic-care hospital or nursing home. (This may also occur when a caregiver's ability or willingness to provide care changes.)

- Admission to an acute-care hospital. (As many as 25 per cent of those over the age of 75 have problems appropriate for geriatric assessment.) Virtually all elderly patients admitted with fractures will need this approach.

- Repeat visitors to the emergency room, especially when polypharmacy is involved.

- Persons with stable physical and mental disabilities should be screened for potential improvement (if not previously assessed).

- Persons with irreversible conditions, e.g. the terminally ill and persons with dementia, should not be excluded.

- High-risk users must be identified at an early stage before their decline is irreversible. Case finding improves as home-care services develop and when staff work closely with primary-care physicians. In addition to the persons/conditions outlined above, the following high-risk groups have been identified:

  - the very old, especially those living alone.
  - the recently widowed, especially in the absence of supportive relatives.
  - persons with chronic disabling conditions, such as arthritis, stroke, dementia, depression and diabetes.
  - persons recently discharged from hospital – 30 per cent will be back in hospital within six months.

- persons recently relocated, i.e. moving from their present home to a new location, e.g. a care facility.

4. THE ASSESSMENT PROCESS

4.1 Content

The nature and composition of assessment will vary with the goals of each assessment. However, a detailed assessment will look at the following components:

- A general assessment of physical health is a universal requirement. Special attention is paid to visual or hearing impairments; deficits of language, cognition and mood; nutritional status; and conditions contributing to poor mobility and falls.

- The person's mental health must also be assessed, including his/her behavioral and emotional status. Such assessments are commonly directed to delineating depression, delirium and dementia. Where psychiatric disorders are suspected or identified, a more comprehensive specialized psychogeriatric assessment may be required. The assessment process for elderly persons with psychiatric disorders has been covered in detail in a recent Federal document.[5, 6] It is therefore recommended that this document be used in conjunction with these guidelines.

- An assessment of the functional status should include evaluation of the ability to carry out basic activities of daily living (ADL), such as dressing, eating, etc. and cognition and judgement, e.g. financial management, medication management, etc.

- The person's family and other caregivers, including the family physician, must be included in the assessment process, and any plan of action must have the willing cooperation of the patient. Present and potential caregivers must be assessed with regard to their competence, willingness to provide care, and acceptability to the older person.

- Another important part of assessment is the physical environment in which the person is living. A home visit provides valuable information on the person's ability to cope and on the suitability of the setting. It will also

5 Health and Welfare Canada, *Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders*.

6 Health and Welfare Canada, *Guidelines for Services to Elderly Residents with Mental Health Problems in Long-Term Care Facilities*.

identify potential hazards and conditions that can be improved to allow the person to remain at home, e.g. structural alterations to allow for wheel chair access.

- The person's quality of life, lack of suffering and general satisfaction with life must be determined together with the needs of the caregivers. These are not easy things to measure, but they will have an impact on the success of the treatment plan.

4.2 Treatment/Care Plan

A coordinated treatment/care plan must be developed for the person being assessed. Development of the plan will be the responsibility of the interdisciplinary core team (see Section 6, pages 17–21), the patient and family members, where appropriate, and representatives of other disciplines/services that are required to meet the patient's needs. The responsibilities of the staff carrying out the plan should be defined. Requirements for coordination of care should be identified along with treatment goals, therapies and expected outcomes. The plan should emphasize the person's strengths as well as his/her deficits. The plan must have the willing cooperation of the patient, the family and other caregivers.

The plan must be monitored on a regular basis to identify changing needs, to evaluate treatment outcomes and to update assessment, treatment and rehabilitation requirements. In the elderly, "cure" of the presenting problem may not be possible - the aim then is to restore and/or maintain as many activities of daily living and more complex social functions as possible. See Table I, page 12 "Problem Assessment Approach to Geriatric Health Services."

4.3 Organization

Assessment in Canada takes place within a variety of systems[7] and settings which will vary according to the patient's needs, geographic location, availability of resources and the structure of local, regional and provincial services. However, whatever system or setting is used, the assessment, treatment and rehabilitation process should be comprehensive and coordinated to avoid gaps, duplication and delays in service delivery. Delays can result in further deterioration of the patient's condition, leading to the need for a higher level of care.

7 See Health and Welfare Canada, *Assessment and Placement for Adult Long-term Care: A Single-entry Model*.

Systems and services currently assessing the elderly in Canada include:

- Visiting Interdisciplinary Teams (these teams visit patients in hospitals that do not have specialized assessment services and/or visit the patient at home)
  - hospital based
  - community based
- Outreach Clinics
- Outpatient Services (Specialized)
- Short-Stay Assessment and Treatment Units
- Day Hospitals (See Section V, pages 25–32)
- Continuing-Care Hospitals
- Multi-level Long-Term Care Centres
- Geriatric Rehabilitation Programs
- Acute-Care Hospital Interdisciplinary Consultation Teams
- Acute-Care Hospital Geriatric Assessment Units (see Section IV, pages 13–24)

4.4 Outcome and Follow-Up

Geriatric assessment and treatment must be part of a coordinated system of care (see Introduction, pages 1 to 2). Assessment and treatment will not be effective if appropriate follow-up resources are not available in the community.

Planning for discharge should take place on or before admission, e.g. in some programs it must be guaranteed that the setting from which the patient has come will be willing to receive him/her back again. If the patient is living at home, pre- and post-discharge visits to the home are necessary.

Adequate follow-up must be available (see 4.2, page 10, Treatment/Care Plan).

PROBLEM ASSESSMENT APPROACH TO GERIATRIC HEALTH SERVICES

Table I

Function	Purpose	Delivery Site
Appraisal	To compile an inventory of the assets and deficits of an individual at place of first contact and within his/her usual environment from the viewpoints of social functioning and of mental and psychological functioning. To assess the patient for presence of disease or disability.	
	To assess the impact of family/friends on the condition of the individual.	
	To establish the base and priorities for the therapeutic program and program implementation.	**All** of these functions may be delivered at:
Intervention	Medical, nutritional, pharmacological, psychiatric and surgical manoeuvres designed to eradicate, arrest, or reverse diagnosed organic disease or disability.	· Private residences · Locations providing ambulatory care
	Measures of physical rehabilitation to improve or maintain level of physical functioning.	· Institutions providing residential accommodation
	Assistance measures to improve or maintain the social environment.	· Institutions providing health care
	Socialization measures to maintain or improve level of social interaction.	
	Professional health care measures to improve or maintain health balance.	
Evaluation	To determine the effects of the intervention measures with a view to maintaining or appropriately modifying the patient treatment program.	

■ GERIATRIC ASSESSMENT AND TREATMENT UNITS GUIDELINES

The guidelines that follow are one of a series of guidelines for institutional services. They mainly address the acute-care hospital assessment and treatment services that are a component of the spectrum of services that the elderly may require.

1. PROGRAM ALLOCATION

Within a province or a region, the recommended distribution of units should take into account the following factors:

- regionalization policies;
- centralization and rationalization of services;
- medical and socio-demographic characteristics;
- geographic location;
- environmental conditions;
- availability of professional staff.

Experts in the field describe assessment in various ways: geriatric assessment; geriatric assessment and treatment; treatment and rehabilitation; and long-term follow-up. Some hospitals only undertake assessment, but treatment and follow-up must be available elsewhere in the community or the assessment is pointless. Not every hospital will have a geriatric assessment unit, but all hospitals should have access to a unit or to a specialized consultation service or team. Specialized geriatric services should support the family physician in prevention, diagnosis, treatment, and rehabilitation of his/her elderly patients. However, many elderly persons admitted to hospital on an emergency basis do not have a regular physician. Many are housebound and are unable to find a physician who will come to their homes. For these persons, identifying an appropriate source of continuing medical care becomes a priority.

2. PATIENT LOAD - INPATIENT UNIT

The patient load of a unit is the most important determinant in personnel resources and space requirements. When estimating potential patient load for a new unit, the following demographic and utilization data indices should be considered:

- age- and sex-specific population projection;
- utilization (separations);
- patient referral rates;
- morbidity/mortality factors;
- dependency levels - estimation of degree of independence in activities of daily living;
- complication rates.

(See also Section III, 3., pages 8 and 9.)

3. BED REQUIREMENTS

Most units in Canada have between 20 and 25 beds. This size appears to be the most convenient for administrative and economic operation of the unit, e.g. staffing ratios are more easily organized around this number or multiples thereof. The maximum administrative size of the unit would be 40 beds.

From collective experience it has been shown that a 20-bed unit could accommodate approximately 300 patients having a median length stay of 20-30 days and a maximum stay of 60 days.

The length of stay will vary according to the services that the unit provides. Where a unit is primarily an assessment centre and patients are referred back to the original service – to a geriatric rehabilitation program, geriatric day hospital or other appropriate community services - their average length of stay would be much shorter. Where a unit provides assessment and treatment services, the median length of stay would be longer. Units are usually established as separate facilities and not as part of an internal medicine ward. Examination of utilization patterns of similar units would be helpful in estimating the patient load and length of stay.

4. NON-BED UNIT REQUIREMENTS

Personnel required to support the unit are defined in Section 6 – Personnel Requirements. Other supporting departments and services that are part of an acute-care hospital will often be required. Staff attached to these services should be made aware of the special needs of the elderly persons that they will be serving. The following services will normally be required:

- Laboratory Services
- Electrodiagnostic Services
- Diagnostic Imaging (X-Ray, Ultrasound, Nuclear Medicine)
- Library Services
- Acute-Care Hospital Services (other than those listed in Section 6, page 17)

The workload of other inpatient services required to support the unit will need to be estimated.

5. PROGRAM ORGANIZATION AND POLICIES[8]

5.1 Medical Staff

5.1.1 Medical Direction

A medical director for the unit should ideally be a geriatrician (see 6.1, page 19). The director should provide leadership in developing geriatric programs and policies and have major responsibility for quality of care and appropriate utilization of the unit. The director would also have responsibility for some patient management.

5.1.2 Medical Staff

The patient's own physician should be involved in the care of the patient to help ensure continuity of care. The degree of involvement will vary according to hospital policy; however, the medical director must have authority for admission, management, and discharge of patients in the unit. Physicians treating patients in the unit must comply with medical staff by-laws, rules and regulations.

8 See also Health and Welfare Canada, *Adult Long Term Institutional Care*, p. 77–85.

5.2 Policies and Procedures

5.2.1 Admission and Discharge Policies

Admission and discharge policies must be established for the unit within the general hospital admission and discharge policies. For example:

- The decision to admit a patient is the responsibility of the Unit Director in consultation with the Unit Nurse Manager.

- An elderly person is appropriately admitted to the geriatric unit if his/her condition does not require care in another specialized unit, such as intensive care or coronary care.

Ideally, geriatric units should have priority access to other components of a geriatric service, such as rehabilitation, community services, and long-term institutional care. For example, if a patient requires prolonged rehabilitation, access to a rehabilitation unit within a reasonable time is desirable.

5.2.2 Access to the Unit

An elderly person may gain access to a geriatric unit as follows:

- by referral from other elements of the hospital's geriatric program;
- by referral from the community;
- by referral from other treatment units of the hospital, including emergency;
- by referral from family physician.

5.2.3 Patient Management

When a patient is admitted, the assessment process, as described in III, 4.1, will be carried out. A composite health-care-needs profile of the patient will be formulated. Recommended interventions and the role of each discipline will be delineated. (See III, 4.2 – Treatment/Care Plan, page 10.)

5.2.4 Separation from the Unit

The separation/discharge planning should be part of the total treatment/care plan. Objectives should be set and adjusted as necessary in consultation with the patient. Separation from the unit may be by discharge to a home environment, by transfer to another facility, or by death. Separation can be:

- unsupported, if the patient is able to return to a home environment and cope alone with just the assistance of helping individuals;

- supported, if formal institutional or community day services, such as home care, are required on a regular basis for the patient to cope with the day-to-day demands of living.

When separation is expected, community support programs should be identified, informed and involved appropriately. (See also III, 4.4, page 11.)

5.3 Duties and Responsibilities of Staff

5.3.1. The duties and responsibilities of staff must be in written form for all positions to accommodate the special needs of the elderly. There must be flexibility in traditional work roles and times of work, i.e. scheduling of meals, treatments, etc. to suit patient needs as much as possible rather than to suit the needs of the facility.

5.3.2. Unit staff should be available to provide consultation to other departments in the hospital and the community. Appropriate resources should be available to do this.

5.3.3. A team approach to care should be organized to allow appropriate expertise to be made available to the patient and also to help ensure an integrated approach to patient care.

5.3.4. Unit staff should provide educational programs and services to other health personnel in the facility to raise awareness of the needs of the elderly. Staff should also encourage and participate in research activities related to aging. Again, resources should be available to support this program.

6. PERSONNEL REQUIREMENTS

Staff should have a clear understanding of the special needs of the elderly in order to provide adequate care, support and assistance to patients and their families. Basic knowledge requirements would include knowledge of the fundamentals of assessment, rehabilitation, remotivation therapy, attitude orientation and behaviour modification.

The interdisciplinary team is an essential part of geriatric management. Staff must be able to work effectively as members of a team that is committed to achieving the goals of the care plan.

Membership of the team will depend on the scope of the program. However, the team will always contain a core group of professionals and a wider group of support professionals and consultants. The patient, the family

physician and other significant caregivers are included as members of the core team. The core group will normally consist of at least:

- Physician (Geriatrician)
- Nurse
- Physiotherapist
- Occupational Therapist
- Social Worker.

The extended team – some of whom are often in the core group - will normally include staff from the following disciplines:

- Audiology
- Chaplaincy
- Chiropody
- Clinical Nutrition
- Clinical Psychology
- Dentistry
- Ophthalmology
- Other Medical/Surgical specialties
- Pharmacy
- Podiatry
- Prosthetics and/or Orthotics
- Psychiatry - Psychogeriatric support
- Recreology
- Rehabilitation Medicine Specialist
- Speech/Language Pathology
- Volunteer Services.

Other disciplines and services required to support the unit are defined in Section 4, page 15.

Members of the core team are usually employed on a full-time basis. Staff in the extended team must have the time that they spend in the unit clearly defined and actively assigned to the unit. Where the services of a staff member from another department are assigned to a unit on a part-time basis, it is important that this role not be fragmented by assigning different staff on different days. Continuity of care and job satisfaction are enhanced when staff and patients are familiar with each other.

The core team is typically led by the geriatrician, although increasingly the case management model is being used, where any one of the team members coordinates the assessment and management of a patient. The team meets regularly to discuss clinical cases and program development. Although each team member has a particular set of skills, the effective team must

recognize the boundaries of each professional and allow some blurring of his/her roles to ensure effective team functioning.

Qualifications and training should be in keeping with professional standards and the defined needs of the program and the patients. The actual numbers of staff required will vary according to the size or scope of the program. Provincial staffing guidelines should be consulted when estimating staffing requirements.

6.1 Medical Staff

There should be a designated Clinical Director of the unit who has specialized skills in geriatric care, and the unit should have assurance of adequate medical coverage. The Clinical Director should ideally be a geriatrician – (a qualified internist who has taken additional approved training in geriatric medicine and who is certified as such by the Royal College of Physicians and Surgeons of Canada).

Physicians working in the unit (see 5.1.2) will be expected to:

- assist in detailed patient evaluation;
- work with and support the team by active participation in conferences and discussions;
- assist, as appropriate, in discharge planning and follow-up;
- assist in evaluation of effectiveness of care;
- participate in the educational and research activities of the unit.

6.2 Nursing Staff

The Unit Nurse Manager must be a clinical nurse specialist or a registered nurse with interest, training, and experience in assessment, treatment and rehabilitation of the elderly. Nurses in senior positions should have advanced preparation in geriatric nursing or a related field. All nurses should have proven skills in clinical, managerial, education and consultation techniques. Hours of nursing care per patient day will be based on program goals and occupancy ranges.

6.3 Social Work

Social work staff should be trained and qualified to participate in the management of elderly patients. This normally requires qualification at the M.S.W. level, together with specific clinical training in geriatrics. Social workers take particular responsibility for liaising with the multidisciplinary team and the patient's social environment. The social worker's collaborative relationships with team members and agencies in the community assist

patients to gain access to needed resources and services, such as social assistance and accommodation.

6.4 Occupational Therapy

Occupational therapists should be graduates of a recognized university program or equivalent. They should also have training in geriatric services. The practice of occupational therapy includes, but is not limited to, consultation and evaluation to assess the physical, mental, social and developmental capabilities of the patient. A planned occupational therapy program should be integrated into the total care plan in order to use functional activities to maintain and improve existing performance in self-care, work and leisure skills, as well as to promote and develop latent skills. Occupational therapists frequently assess the patient's home prior to discharge. Occupational therapy staff provide education and support for other staff and for volunteers.

6.5 Physiotherapy

Physiotherapists should be graduates of a recognized university program and have training in geriatric services. The objectives of the physiotherapy service are to prevent or minimize disability, to increase level of performance, functioning and communicating, to promote social resettlement, to maintain current levels of functioning and to compensate for deficits. Following assessment, the treatment plan may include the following: training to return to maximum self-care, sensory stimulation, specialized exercise programs, passive movements, self-help devices and specialized equipment, positioning for good body alignment, training to improve mode of transfer and ambulation, and specialized treatment, such as hydrotherapy. Physiotherapy staff provide education for other staff and/or volunteers in areas such as proper methods of handling, lifting and transfers and special techniques for individual patients.

6.6 Other Direct-Care Staff

As previously stated, other health care professionals will often be members of the core group or be called on for consultation. Requirements for staff are outlined under Section 6, page 17.

6.7 Support Staff

Receptionist, secretarial staff and other support staff, e.g. activity aides, are required by the program.

6.8 Orientation and Continuing Education

An orientation program for staff who will be working in the unit is essential. The program addresses areas such as the philosophy and goals of the program, the roles of the team members, the relationships with other departments and community agencies, orientation, and introduction to existing clients and to the other team members.

All members of the assessment treatment team should update their skills on a continuing basis by attending case conferences, seminars, post-graduate courses and lectures. There should be an in-service education program, preferably directed by a designated person who would be responsible for structuring courses. Staff should have ready access to reference material and library services.

7. EQUIPMENT

7.1 Aids to Mobility and Communication

Aids designed to meet the mobility and communication needs of geriatric patients include:

- appropriately designed chairs;
- low beds;
- mechanical lifts;
- wheel chairs;
- tilt tables;
- walkers;
- canes;
- crutches;
- hearing aids/microphones for the hearing impaired;
- telephones for patients.

7.2 Recreational Equipment

Recreational equipment and supplies should include sound equipment (record player, tape recorder, radios, etc.), television, and video-cassette recorder, as well as equipment and supplies for other appropriate activities.

7.3 Library Services

Library services are required and should include large-print books and talking books. Magnified lights for reading are also required for the visually impaired.

7.4 Aids to Daily Living

Specially adapted equipment for daily living should be standard unit equipment. The type and extent of adaptation will be determined in consultation with occupational therapists and other staff knowledgeable in this area. A specially adapted kitchen is often recommended for therapeutic and assessment activities. Laundry facilities for personal laundry should be available on the unit to promote maximum independence of residents.

7.5 Medical Equipment

Medical and nursing equipment for assessing and treating the elderly will be required, especially appropriate examining tables.

8. SPACE ALLOCATION AND SPECIAL DESIGN FEATURES[9,10]

The design of the physical environment must take into consideration the patient's physical, functional, mental and psychosocial impairments which result from illness and/or the aging process. Attention must be given to the protection of confused and wandering patients. The patient's total comfort must be supported to the maximum extent possible by considering, among other things, such sensory cues as light, colour, and texture.

8.1 Primary Activity Areas

8.1.1 Bed Space

Because of the long-term nature of the patient's stay and the common use of wheel chairs, walkers and other equipment, a much larger-than-average room is required. A mixture of single and double rooms is recommended.

9 For detailed consideration of these factors see Health and Welfare Canada, *Living Accommodations for Seniors, Facility Planning and Design Guidelines, Vol. 3, Accommodation for Continuing Care Living*.

10 See also Health and Welfare Canada, *Adult Long Term Institutional Care*, p.77–85.

8.1.2 Other Components

Regular bathing and toilet facilities are required, as well as special adaptation of these facilities to accommodate the needs of the handicapped; for example, wheel chair showers, full-size adapted baths, wheel chair-height basins in patient's bedrooms. Full-length mirrors are required to examine personal appearance and also posture. Closet space must be allowed for storage of personal clothing (indoor and outdoor) and for optimum mobility of patients using all types of mobility aids.

8.1.3 Examining and Assessment Space

A room for treatment and examinations will be required. Space will be needed for interviewing patients and their families.

8.1.4 Medical, Nursing and Professional Staff Requirements

Office space will be required for professionals working in the unit. A room large enough to accommodate team conferences will be needed. Because of the confused nature of some patients, space will be required for safe storage of all medications, lotions, equipment, cleaning supplies, etc. A locked cupboard is needed for dangerous drugs.

8.1.5 Activity and Recreational Space

A minimum of 3.7 m^2 per patient is required. As the majority of rehabilitation therapy will take place on the unit, space must be provided for group activities. In addition, some private space for quiet activities and private communication with family and friends is required. Easy access to outside space is recommended.

8.1.6 Dining Areas

A dining area is considered essential to promote socialization and to assess social skills in a more natural setting than the normal hospital environment. Patients are encouraged to eat lunch and dinner in the dining area. A minimum of 1.67 m^2 to 1.86 m^2 per patient is recommended.

8.2 Support Areas

- Utility
- Storage
- Waiting Room

8.3 Administration Areas

- Space for record keeping.

GERIATRIC DAY HOSPITAL GUIDELINES

A geriatric day hospital is defined as a place which has an organized day program for the elderly and that is related to a hospital or other health care agency.[11] *It serves the elderly who require preventive and diagnostic services, multidisciplinary assessment, and rehabilitative or therapeutic services during the day, for some part of the week or on a regular basis.*

The purposes of day hospitals are to conduct investigations and assessments, to provide treatment and rehabilitation, to give maintenance care that may otherwise have necessitated a hospital admission and to provide respite to caregivers at home. Day hospitals are often located in acute-care hospitals, especially since some situations require investigation that demands access to complex diagnostic equipment. Day hospitals are sometimes located in long-term care settings if the main focus is on rehabilitation or less complex medical management.

The day hospital should make provisions for:

- medical and nursing care services;
- occupational therapy and physiotherapy programs;
- mental health programs;
- nutritional programs;
- lifestyle programs;
- socialization and activation programs;
- medication review services;
- various other types of supportive therapy, e.g. audiology and speech therapy, podiatry, etc.;
- substance abuse programs;
- diagnostic services;
- social work and Legal Aid services;
- coordination with community agencies and services;
- palliative care;
- personal care and hygiene programs;
- pastoral care;
- respite care;

11 Geriatric night programs can also be developed to provide respite care, allowing overnight rest for the caregiver.

- a variety of activity programs with therapeutic orientation, e.g. exercise programs;
- counselling and support for the patients and their families, e.g. support in dealing with grief, loss, problems with sexual functioning.

Individuals may come by themselves or be brought to the facility, spend several hours in one or more of the various therapeutically oriented programs and then return home on the same day. The long period of time (four to six hours) each day of attendance, and the integration of the various programs into a single delivery mode, differentiate a day hospital from traditional physical medicine or ambulatory-care departments. It has been demonstrated that day hospitals provide:

- assistance to the elderly in attaining or maintaining a degree of health adequate for them to cope with the demands of living in the community;

- comprehensive multidisciplinary assessment services;

- supportive services and follow-up care for individuals discharged from hospitals or institutions;

- supportive services to the individual and family, which may prevent or delay admissions to institutions;

- prevention of physical and mental deterioration through education, resocialization, and activation;

- a means of monitoring and evaluating the health status of individuals attending, to determine whether the person is benefiting from the program;

- relief for persons who are caring for the individual at home.

1. PATIENT LOAD

For effectiveness and efficiency of operation, the recommended patient load is between 15 and 50 patients in attendance at any one time. The optimum range is between 25 and 35. Where patient load falls below 15, arrangements should be made to accommodate these patients in other local programs. Services are generally available five days a week.

2. INPATIENT CAPACITY

The establishment of a day hospital may have the effect of reducing the number of admissions to the inpatient unit. Apart from potential cost saving, care given on a day basis is often less disruptive for the patient and promotes independence.

3. NON-BED UNIT CAPACITY

In addition to the services outlined for inpatient services and the services and programs defined above (see pages 25 and 26), the following services will be required to support the geriatric day hospital.

3.1 Transportation Services

An organized transportation service is essential to the success of a day hospital, and funding will often be required for this service. Neighbours and relatives cannot be relied upon to provide regular transportation services. Patients should be picked up and taken home. The driver or porter should ensure that patients arrive home safely. Transportation time should not exceed one hour.

Individuals in rural communities are often not able to take advantage of facilities because of the distances involved and the difficulties with transportation. Accordingly, special consideration should be given to these patients.

3.2 Volunteers

Volunteers can be of great help in a program of this nature. They can provide support services, such as assisting the patients in the activities of daily living programs and providing escort services for patients who have to go to other departments for treatment or services.

3.3 Other Services

Availability of barber and hairdressing services, and clothing and footwear services for the disabled, will be required.

4. PROGRAM ALLOCATION

Geriatric day hospitals should be related to geriatric units. Where this is not possible, they should be attached or related to other health facilities. Decisions concerning the distribution of day hospitals should take into account the following factors:

- regionalization;
- centralization and rationalization of services;
- medical and socio-demographic characteristics;
- geographic location;
- environmental conditions;
- professional manpower supply.

5. PROGRAM RELATIONSHIPS

Program relationships include internal and external linkages and have an impact on programs. They also refer to proximity needs as they affect:

- communication;
- sharing of special services;
- circulation of patients;
- staff and materials.

Where an inpatient geriatric unit exists, it may be possible to share staff between both programs. Special services, equipment and facilities could also be available to both programs. The availability of day services would ensure that appropriate patients from an inpatient unit can be discharged to a supportive day program. This frees beds and ensures continuity of care for the patient.

6. PROGRAM ORGANIZATION AND POLICIES[12]

6.1 General Objectives

The aims and purposes of the day hospital must be clear and fully understood by the Board, administration, and professional staff of the facility in which it is located.

6.1.1 The Medical Director for the day hospital must have clearly defined lines of responsibility and authority for the implementation of policies on admission, management, and discharge of all patients attending the day hospital.

6.1.2 the Medical Director should be a geriatrician or physician with demonstrated interest, training, and experience in the care of the elderly.

6.1.3 If the geriatric day hospital is situated in a hospital with a geriatric unit, the Medical Director could have responsibility for both these services.

6.1.4 The physician most responsible for the patient must be identified. This doctor can be the patient's personal physician, working in conjunction with the Medical Director, or possibly the Medical Director him/herself.

6.2 Policies

6.2.1 Admission and discharge policies, which include program and discharge planning, should be established within the context of those of the parent facility. They could include:

- Admission by consultation with or referral to the Medical Director and with review by the Admission and Discharge Committee.

- Admission upon request from other elements of the geriatric program, including patient's own physician, community agencies, family, friends, or self.

- Discharge on the recommendation of the treatment team which has made appropriate arrangements for the continuity of care.

6.2.2 Patient management should be based on a composite health needs profile, produced after an initial needs appraisal carried out by an interdisciplinary team, (as outlined in Section III, 4.1, pages 9 to 10). A plan should be

12 See also Appendix IV – *List of Guidelines for Institutional Programs*.

developed for continuing care, which should be implemented and evaluated periodically by team members.

6.2.3 Policies for emergency situations are required.

7. PERSONNEL REQUIREMENTS
(See Section 6, page 17)

Staff duties and responsibilities include the following:

- assessment, development, and implementation of individual care plans.
- planning for evaluation and modification of treatment, as required.
- establishment of clearly defined lines of communication with other components of the area geriatric service and with health and social agencies involved in programs such as Home Care and those provided by the V.O.N.
- education and support for patient and families.
- participation in educational activities for health service personnel and in research.

7.1 Medical Staff (See Section 6.1, page 19)

A Medical Director (see Sections 6.1.1 and 6.1.2, page 29) should be appointed and external consultants used as required.

7.2 Direct Patient Care Staff

A program coordinator should be appointed who is a health professional with management skills.

It is necessary to have access to staff with skills to deliver the programs and services listed on pages 25 and 26. Personnel requirements are described in detail in Geriatric Assessment and Treatment Units Guidelines, Section 6, pages 17 to 21.

Staff involvement in these activities may be full-time or part-time. Continuity of staff assignments is arranged through the appropriate departments. Volunteers may be used where appropriate.

7.3 Support Staff

Support staff, for example a receptionist, a clerk and a bus driver, are required.

8. EQUIPMENT[13]

Each service or activity will have equipment needs that will involve financial expenditure and storage requirements. Budget and space requirements will therefore be a major consideration when establishing the program components; activities could range from those requiring no equipment - singing and movement – to those requiring elaborate equipment, e.g. activities of daily living, kitchen equipped for assessment and training.

- A separate rest area with beds, cots, or reclining chairs is required by patients for prescribed rest periods. The recommended ratio is at least one bed (cot, chair, etc.) per six patients.

- Laundry equipment is required so that clients can be encouraged to achieve and maintain maximum personal independence.

- Hair dryers and hair-washing basins, if required.

9. SPACE ALLOCATION AND SPECIAL DESIGN FEATURES

9.1 Primary Activities Areas

Easy access to all areas by patients using wheel chairs, canes, or walkers is essential. All furnishings, fixtures, toilets, etc. must be designed to accommodate wheel chair patients. Access to outside areas, such as gardens or recreational areas, is desirable. Many of the design and space considerations for a geriatric unit (listed on pages 22 to 24) also apply to the geriatric day hospital. Depending on location, some of the facilities may be shared, e.g. activities of daily living kitchen.

13 See also Section 7 – Equipment, p. 21–22.

9.1.1 Rest Area

As outlined in Section 8 above.

9.1.2 Group Activities

Space allowance must be made for a number of group activities to occur simultaneously.

9.1.3 Examination and Treatment Rooms

Separate rooms will be needed for treatments that require privacy, for specialty examination and treatment such as podiatry, optometry and dentistry, and for specialized counselling, such as medication or sexual counselling.

9.1.4 Interview Room

Rooms will be required for private interviewing of the patient and/or family.

9.1.5 Shared Facilities

If the unit is part of a larger facility, patients may receive some service in another department, e.g. occupational therapy or physiotherapy.

9.1.6 Toilet and Bathing Facilities

Toilet and bathing facilities are essential and should include an "assist" bath or wheel chair shower. There should be one toilet for every five patients.

9.2 Support Areas

9.2.1 Personal Storage Space

Large lockers will be required for storage of clothing, personal possessions, and project/handwork materials. As there will be more clients attending during a week than on any one day, an excess number of lockers will be required.

9.2.2 Barber and Hairdressing Services

Space for barber and hairdressing services is desirable.

■ APPENDICES

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III ADMINISTRATIVE ORGANIZATION, POLICIES AND PROCEDURES

Guidelines for administrative organization, policies and procedures for institutional and community programs were formulated after a review of provincial, national and international information.

It is hoped that the following outline will serve as a guide for the development of more comprehensive and specific policies to ensure the most effective delivery of patient care in these units.

PHILOSOPHY, ROLES AND OBJECTIVES

- Philosophy, roles and objectives of the program
- Type of patients served
  - By diagnosis and/or severity of illness
  - Restriction of service, if any
- Services provided

ORGANIZATION OF PROGRAM

1. General

- Governing board responsibility
- Relationship with administrator and medical staff
- Program management

2. Specific responsibilities of staff

- Medical director
- Other medical staff
- Nursing staff
- Other staff

3. Committees

- Membership to be defined by discipline and number
- Terms of reference to be defined
- Provision for consultation with appropriate hospital and medical staff and other health agencies
- Schedules for formal and ad hoc meetings

POLICIES FOR OPERATION OF PROGRAM

1. General

- Admission authority (identification of individual(s) who have authority to admit)
- Admission priorities by
  - diagnostic category
  - clinical condition
- Admission orders
- Medical orders
- Emergency admission standing orders
- Discharge policies and planning
- Length of stay by diagnosis
- Infection control and isolation
- Patient records, reports and charting
- Handling of emergency situations, including cardiopulmonary resuscitation
- Emergency delegation of responsibility to medical, nursing and/or other staff
- Research/clinical investigation
- Palliative care, determination of death, authorization for autopsies, handling of bodies
- Referral, consultation (mandatory and other, transfers, follow-up)

2. Staff

- Selection criteria: education, experience, interests
- Criteria for granting medical/clinical privileges
- Medical coverage/staff coverage of service
- Delineation of student and supervisor roles, including responsibility, authority and accountability
- Position descriptions
- Orientation and continuing education
- Performance evaluation
- Volunteers

3. Patient

- Patient's rights
- Patient identification
- Family participation
- Confidentiality
- Patient/family education
- Patient valuables, assets and belongings
- Consent for treatment
- Visiting privileges

4. Safety

- Safety and accident prevention
- Reporting of accidents and incidents
- Equipment maintenance, safety and medical alert bulletins
- Fire and disaster plan
- Use of restraints

5. Quality Assurance

- Practice standards
- Continuing evaluation of effectiveness of service
- Patient status assessment on admission and discharge
- Incident reports
- Patient care review
- Infection control
- Audits: medical and nursing care, concurrent and retrospective
- Peer review
- Morbidity/mortality review
- Employee performance appraisal
- Product and equipment use and evaluation

PROCEDURES

- Elective procedures
- Emergency-alert system procedures
- Medical record and statistical procedures
- Policy and procedure manuals

IV LIST OF GUIDELINES FOR INSTITUTIONAL PROGRAMS

The following guidelines have been prepared by the Federal/Provincial/Territorial Subcommittee on Institutional Program Guidelines. These guidelines were requested by the Federal/Provincial/Territorial Advisory Committee on Institutional and Medical Services. Some of the guidelines are updated versions of those previously published by the Subcommittee.

Addiction Services in Hospitals (1984)
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Organ and Tissue Donation Services in Hospitals (1986)
Palliative Care Services (1989)
Patient Hostel Unit (1978)
Perinatal Intensive Care Units in a Perinatal Care Network (1986)
Pre-Hospital Emergency Care Services (1985)
Pulmonary Function Laboratories (1982)

Rehabilitation Medicine Program (1986)
Respiratory Therapy Service (1987)
Services to Elderly Residents with Mental Health Problems in Long-term Care Facilities (1990)
Spinal Cord Injury Program (1986)
Stroke Program (1986)
The Reuse of Disposables: An Information Report (1985)
Vital Organ Transplant Centres (1986)